Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METROPLEX SURGICARE
1600 CENTRAL DRIVE SUITE 180
BEDFORD TX 76022

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-3874-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached claim was not paid according to the 2009 Ambulatory Surgical Center Fee Schedule. We are disputing the allowed amount of both charges of CPT #63650 on this device intensive claim. We requested that the carrier pay the claim with the device at 100% of CMS and 235% on the service. The allowed amount of each charge should have been $4,860.97 each."

Amount in Dispute: $1,203.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question, CorVel bill number 9/1448102 has an allowed amount of $8,518.50 on 9/22/09. The recommended allowance was based on the HCP's contract with Integrated Health Plan (IHP). Per the aforementioned contract the provider is to be reimbursed at 25% off of the billed amount."

Response Submitted by: New Hampshire Insurance Co., 300 South State St., Syracuse, NY 13702.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2009	ASC Services for code 63650 (X2)	$1,203.44	$1,090.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract and that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 22, 2009
   - 45-Contract/Legislated Fee Arrangement Exceeded.
   - W1-Workers' Compensation State Fee Schedule Adj.

   Explanation of benefits dated November 3, 2009
   - 45-Contract/Legislated Fee Arrangement Exceeded.
   - 168-No additional allowance recommended.
   - 193-Original payment correctly processed 1st time.

Issues

1. Does the submitted documentation support a contract exist between the parties for the disputed services?
2. Did the requestor support position that additional reimbursement is due for ASC services for code 63650? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. Texas Labor Code Ann. §413.011(d-3) states the division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the division.

   On September 28, 2010, the Division submitted a notice requesting a copy of the contract between the network and the health care provider in this dispute. The insurance carrier's representative acknowledged receipt of the notice on September 29, 2010. The notice provided for a deadline to submit the requested information no later than fourteen (14) days after receipt of the notice. The insurance carrier failed to provide a copy of the requested documentation. For that reason, the services in dispute will be reviewed in accordance with 28 Texas Administrative Code §134.402.

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   The requestor billed for two (2) units of CPT code 63650 on the disputed date of service. CPT code 63650 is defined as "Percutaneous implantation of neurostimulator electrode array, epidural."

   CPT code 63650 is a device intensive procedure.

   28 Texas Administrative Code §134.402(f)(2)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (2) Reimbursement for device intensive procedures shall be: (A) the sum of: (i) the ASC device portion; and (ii) the ASC service portion multiplied by 235 percent."

   28 Texas Administrative Code §134.402(f)(2)(A) reimbursement for device intensive procedure code 63650 is a two step process:

   Step 1 calculating the device portion of the procedure:
   The national reimbursement is found in the Addendum B for National Hospital Outpatient Prospective Payment System (OPPS) HCPCs code 63650 for CY 2009 = $4,206.45.

   This number multiplied by the device dependent APC offset percentage found in the Addendum B for National Hospital OPPS reimbursement of 57% = $2,397.67.

   Step 2 calculating the service portion of the procedure:

The Medicare fully implemented ASC reimbursement rate is found in the Addendum AA ASC Covered Surgical Procedures fully implemented ASC relative payment weight for CY 2009 = 83.8876.
This number is multiplied by the 2009 Medicare ASC conversion factor of 83.8876 X $41.393 = $3,472.35.
The Medicare fully implemented ASC reimbursement rate is divided by 2 = $1,736.17 ($3,472.35/2).

This number X City Conversion Factor/CMS Wage Index for Arlington is $1,736.17 X 0.9709 = $1,685.64.

The geographical adjusted ASC rate is obtained by adding half of the national reimbursement and wage adjusted half of the national reimbursement $1,685.64 + $1,736.17 = $3,421.81.

The service portion is found by taking the national adjusted rate of $3,421.81 minus the device portion of $2,397.67 = $1,024.14.

Multiply the geographical adjusted ASC reimbursement service portion by the DWC payment adjustment $1,024.14 X 235% = $2,406.72.

The MAR is determined by adding the sum of the reimbursement for the device portion of $2,397.67 + the geographically adjusted service portion of $2,406.72 = $4,804.39.

Per 2009 Addendum AA, CPT code 63650 is not subject to multiple procedure discounting. Therefore, since the requestor billed for two units, the total allowable for CPT code 63650 is $9,608.78. The insurance carrier paid $7,206.68. The difference between amount due and paid equals $1,090.28, this amount is recommended for reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $1,090.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,090.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/3/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.